INDIANA Epidemiology NEWSLETTER

Indiana State Department of Health

Epidemiology Resource Center
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This issue of the Indiana Epidemiology Newsletter is devoted to the ISDH response following Hurricane Katrina. The articles describe the request for assistance, the experiences of ISDH volunteers deployed to Mississippi, and the surveillance for health events among residents in the area, evacuees to Indiana, and deployed volunteers. We dedicate this issue to the victims of Hurricane Katrina and the ISDH volunteers who responded.

Call for Indiana's Help

Michael Hurst, Director
Public Health Preparedness and Emergency Response

On August 31, 2005, the Governor of Mississippi requested that Indiana provide assistance for recovery efforts related to Hurricane Katrina. The request was made under the Emergency Management Assistance Compact (EMAC). Mississippi requested a limited, multidisciplinary team for a possible 60-day deployment within that state, subject to missions that would later be identified by Mississippi authorities. Under EMAC, personnel who are identified by a requesting state and rostered by a sending state are entitled to liability protection, professional license transfer, and reimbursement from the receiving state under that state's authority.

On September 1, Indiana received the formal paperwork from Mississippi identifying the personnel resources that state was requesting. That paperwork requested that Indiana supply a "self-sustaining task force comprised of 80 law enforcement, 35 water rescue, 5 to 12 mental health, 2 to 10 forestry crews, and [a] 24-member medical team." This paperwork also specifically detailed the location to which these out-of-state resources should deploy (DeSoto County Civic Center) and estimated the cost that Mississippi would incur as a result of Indiana providing this mutual aid.

On September 1 and 2, the Indiana Department of Homeland Security (IDHS) composed teams of volunteers for the task force described in the request from Mississippi. Each state agency involved in the task force identified specific volunteers in their respective disciplines (e.g., the Department of Mental Health and Addiction [DMHA] identified the mental health volunteers, the Indiana State Department of Health [ISDH] identified the medical/public health volunteers, etc.). In addition, Mississippi identified and agreed to staff changes that incorporated fire services and

emergency medical services (EMS) and National Guard personnel into the task force, as well as minor adjustments in the numbers of staff from each discipline that were being requested. The disciplines represented and the number of staff from each discipline on the task force were subject to Mississippi's request and approval.

On September 3, Indiana deployed the task force described by Mississippi in its EMAC request. The medical team for the initial and two subsequent deployments included physicians, nurse practitioners, nurses, and respiratory therapists. The early teams were composed primarily of practitioners from trauma, emergency department, and acute care settings. Later deployments evolved to general medical and family practitioners. The medical/public health teams also included an ISDH epidemiologist, an environmental health specialist, and local and state public health coordinators to assist with disease surveillance and control activities. The DMHA also deployed a 10-person mental health team and relieved that group in second and third deployments.

Indiana personnel ultimately deployed to Biloxi, Mississippi, where the task force established a base camp in a large parking area in that city (see photo below). The task force and camp were supported by a heavy contingent from the Indiana National Guard and the Indiana State Police. The Guard erected tents complete with camping cots and lights for all task force personnel. They also transported potable water, fuel, generators, and a portable mess unit.

The medical/public health team provided clinical services in multiple shelter settings. One of these included a walk-in shelter for the employees and volunteers of the Biloxi Department of Public Works, along with their families. This heroic group of public servants, many of whom lost everything to Katrina, was working day and night to restore basic services within the Biloxi community. The medical/public health teams also engaged in community outreach, moving door to door as teams of doctors, nurse practitioners, and nurses. With the third deployment, these teams began to work with providers and hospital staff to assist them in restarting their practices and rebuilding the local provider network.

The Indiana task force was one of many teams of volunteers from multiple states operating in Mississippi, and it was one of a very few that was self-sustaining (meaning that the task force brought its own transportation, food, water, and security). The Indiana task force operated under a deployment schedule that transitioned staff in 14-day intervals. This schedule served task force members who should not have been deployed for periods longer than 14 days. The schedule also supported the incident response needs for Mississippi (to control traffic flowing in and out of that disaster area) as well as Indiana (to provide for transportation and other logistics support for personnel movement and accommodations).

Task force staff disciplines were adjusted with each transition as the missions from Mississippi evolved. For example, the fire services and EMS support teams returned home shortly after the first deployment, because there were no ongoing response activities, and Mississippi had moved into the recovery phase. In contrast, the task force was supporting more medical clinics, and additional medical staff members were added. These internal adjustments were requested by Mississippi through the missions given by that state, and the task force size and costs remained constant.

Many volunteers from many, many disciplines wanted to join this task force. The ISDH solicited volunteers for medical teams through the Indiana Health Alert Network (IHAN), the state medical and nursing associations, and the state hospital association. More than 1,000 prospective volunteers responded, but given the specified size and disciplines composing the task force, not

everyone could be deployed. The first deployment of medical volunteers included 26 people; the second, 33; and the third, 20. Prospective volunteers were updated through e-mail, and many wanted to find other avenues to deploy. The Indiana task force provided a link to the federal web sites where prospective volunteers could also register to join a group going into the affected areas.

Mississippi and Louisiana hosted volunteers from many other groups as well as those who were individually self-deploying. These states imposed restrictions on volunteers who were entering their states and not working under an EMAC request. For example, Mississippi required medical volunteers who were not working under one of that state's EMAC requests to apply for an emergency license to practice within that state. The Mississippi medical licensing board reviewed and approved those applications as needed. The same was true with nurses, who, in addition to applying for an out-of-state license, were required to pay a fee. Louisiana issued a blanket order requesting that volunteers cease coming to that state unless they were coming into the state under a specific EMAC request. The Indiana task force deployed under and remained part of an EMAC mission to Mississippi.

By limiting the Indiana task force in compliance with Mississippi's EMAC request, Indiana efficiently provided the help Mississippi requested without further stressing the scarce resources of that state. Indiana protected the safety of its responders and ensured that they practiced with adequate liability protection and valid professional credentials.

Everyone who responded to Mississippi's request for relief should be commended. All volunteers did extraordinary work at great sacrifice. The Indiana task force rotated hundreds of responders from across the state from public and private sectors and served tens of thousands of Mississippi residents and responders.

Without prior public health preparedness activities, the federal funding to support these activities, and relationships built from these activities, Indiana would not have been able to assemble the comprehensive group of health care providers who served Mississippi during this emergency. Because of prior preparedness planning, Indiana had mechanisms and partnerships in place to quickly solicit volunteers and supplies (including loans of equipment from hospitals) and deploy volunteers as part of a self-sustaining task force.

Camp Indiana at the Gulf Coast Coliseum parking lot, Biloxi, Mississippi.
Photo courtesy of Vicki Wireman, Parkview Behavioral Health.

Volunteer Deployment

Pam Pontones, MA
Director, Surveillance and Investigation

Members of the ISDH Deployment Team:

First Deployment (September 3-September 17):
Susan Bryant, Infection Control Coordinator, Indiana Veterans Home
Cathy Emswiller, Public Health Nurse Surveyor, Long Term Care
Donna Groan, Public Health Nurse Surveyor, Long Term Care
Joe Hilt, Preparedness Coordinator, Public Health Preparedness and Emergency Response
Terry Jackson, Perinatal Nurse Consultant, HIV/STD
Tom Kerr, Chief Nurse Consultant, Epidemiology Resource Center

Second Deployment (September 14-October 1):
Jerry Burkman, Epidemiologist, HIV/STD
Liz Hibler, Quality Assurance Epidemiologist, Epidemiology Resource Center
David Miller, Public Health Nurse Surveyor, Long Term Care
Andy Zirkle, Risk Communication Director, Office of Public Affairs

Third Deployment (September 29-October 14):
Randall Fry, Public Health Nurse Surveyor, Long Term Care
Tanya Williams, Program Director for Local Emergency Response, Public Health Preparedness and Emergency Response

Duties

During the first deployment, the primary tasks of the ISDH team were medical, such as establishing health care clinics, conducting medical assessments and triage, and providing primary medical care in clinic, shelter, and outreach settings. One volunteer reported performing medical assessments by boat. Medical care activities mainly consisted of giving tetanus immunizations, treating wounds, maintaining supply inventories, ordering medications, and providing health education rather than acute disease diagnosis or trauma care. Several volunteers mentioned spending time simply listening to residents and talking with them about their experiences. One volunteer helped provide safety and support for the medical team and planning the next day's tasks with the team leaders, including locations of volunteer missions. Much of the time during the first deployment was a learning experience, spent getting organized, establishing a framework of command-and-control, and interacting with other agencies. In addition to medical care, the first deployment team also performed a variety of other duties, such as distributing cleaning and personal hygiene supplies and clothing and providing outreach support.

In addition to medical duties, which included dispensing medications and providing first aid and immunizations, the second deployment team had more varied roles. One medical volunteer served as a camp administrator, which included tracking camp assignments and volunteers, ordering team supplies, treating patients, listening to staff concerns, and even doing laundry. Another volunteer provided epidemiology support and data analysis, performed needs

assessments, and performed general administrative duties. One volunteer served as the lead public information officer, responsible for maintaining public awareness about Operation Hoosier Relief, issuing press releases, and conducting and arranging media interviews.

Medical support, such as immunizations, triage, primary patient care, and patient education, continued through the third deployment. One volunteer served as the administrative team leader, providing support to the team itself and also working within the Mississippi State Emergency Operations Center, helping to coordinate the overall response and relaying communication.

Volunteer Expectations

Most of the volunteers did not know what to expect, having never been deployed. Many medical volunteers expected more trauma care or needs of an emergent nature, but actually, most medical needs were less severe and more persistent, such as maintaining medications for chronic conditions, treating minor injuries and infected wounds, and providing tetanus vaccinations. Some volunteers had environmental concerns, such as exposure to flooding, mosquitoes, snakes, and alligators, which, fortunately, were not reported. One volunteer reported her experience as "frightening and exciting at the same time."

Some volunteers reported that the experience was similar to what they did expect, but the sheer magnitude of the destruction and survivor stories was more intense. One volunteer expected the experience to be very serious and sad, which was the case upon seeing the destruction and hearing stories from people who had lost everything. However, she never expected to laugh or smile as much as she did, especially with the camaraderie and support of the Camp Indiana staff.

Memorable Situations

Many volunteers related the upbeat spirits of the survivors and how people worked together during this crisis. One volunteer described an elderly couple whose apartment did not have water or electricity. The gentleman had not had any breathing treatments or oxygen use since the hurricane hit. By introducing his wife to a nearby neighbor who still had electricity, the volunteer was able to help re-establish the gentleman's home medical care. Another volunteer commented about a mother and child who visited a clinic. While waiting for the doctor, they talked about riding out the flooding on top of the child's bunk bed. As they sat on the bed, the child's only concern was that her math book and library books were getting wet. They were drying them out page by page. One other volunteer mentioned seeing two survivors in different locations rescuing family members while stranded in 10 feet of debris-laden water for over 10 hours. This same volunteer met an elderly man who was just thankful for what he had and thanked the volunteers "for coming all the way down here to help us out after the storm." One of the most lasting images for another volunteer was a man leaving a church service and saying, "We aren't coming back—we ARE back."

Several volunteers were struck by the hospitality and kindness of the survivors, even in the face of their own challenges. One volunteer reported someone offering to do her laundry because she came to help. Another elderly woman offered to bake a cake for clinic volunteers as a way to thank them. Many survivors offered water to the volunteers, and one shelter provided food as well as smiles and hugs. One volunteer described a phone call from a gentleman treated by one of the volunteer outreach teams. He was a member of a local jazz band, and the group wanted to perform a free concert as a gesture of appreciation despite the intense heat.

Photo courtesy of Elizabeth Hibler, Epidemiology Resource Center

Many of those deployed felt that working with the volunteer team itself was extremely rewarding. According to one volunteer, "They made it happen…with a smile."

Lessons Learned

Many volunteers found the experience personally and professionally gratifying and would not hesitate to volunteer again. Listening and patience were extremely important, and some volunteers mentioned that emotional support and empathy are just as important as medical support and factual communication. Some volunteers appreciated the opportunity to provide direct patient care after performing other duties for the past several years and reported a renewed confidence in those skills. Blending clinical knowledge and organizational leadership involves an informed and respectful appreciation and awareness of each discipline. Finally, after witnessing such destruction, several volunteers mentioned a renewed appreciation for what they have. Said one volunteer, "Personally, it was a truly gratifying and humbling experience that I will never forget."

Photo courtesy of Elizabeth Hibler, Epidemiology Resource Center

Health Event Surveillance

Elizabeth Hibler, MPH
Quality Assurance Epidemiologist
Epidemiology Resource Center

Epidemiology and Data Management Applications During Disasters

Disaster epidemiology, as defined by the Centers for Disease Control and Prevention (CDC), includes surveillance of illnesses and deaths related to a disaster, needs assessment of communities affected by disasters, identification of disaster-associated risk factors, and evaluation of surveillance techniques. The application of epidemiology in the disaster-stricken areas of Gulfport and Biloxi, Mississippi, included these functions and more. The challenge, however, was finding the time and resources in the midst of a disaster response to collect, analyze, and interpret data from the recovering communities.

The variety of applications for data collection and management during the Hurricane Katrina response was surprising. The primary purpose for collecting data was to monitor both the general population and the medical team for potential infectious disease outbreaks. There were also several other applications for data management and reporting. The pharmaceutical inventory changed daily and was, at one point, considered the largest pharmaceutical stockpile in the

region. Information was also gathered regarding medical team activities and the hours each team member worked. Data from each of the functions had applications to both epidemiology and evidence-based planning.

Population surveillance for potential disease outbreaks was a primary activity of the second deployment to Mississippi. The team felt that adequate staff and resources had been provided to allow for the collection of patient information, including age, chief symptom complaint, diagnosis, and treatment. Although it was not possible to complete a detailed analysis of these trends while deployed, the logs were used daily to provide information crucial to evaluating the needs of the community and continued effectiveness of the mission. Counts of the number of patients treated, vaccinations provided, prescriptions written, and pills dispensed were calculated daily and reported to the incident command. These were used as metrics to assess community need and to evaluate the necessity for the continued support of Camp Indiana in the region. This role for evidence-based or data-driven planning cannot be underestimated, even in high-stress disaster situations.

Monitoring the health status of staff was also a concern. The second deployment encountered many individuals with cases of respiratory illness, innumerable insect bites, and an unidentified rash. Practitioners were often asked to evaluate medical staff and individuals from other groups deployed. It is important to develop policies to address documentation of staff injuries or ailments and use of medical resources for treatment. Ensuring that staff remained healthy and addressing personal needs should also be a focus of any surveillance unit.

Documentation for administrative purposes was needed to ensure accountability for supplies utilized and personnel activities. The size and composition of the pharmaceutical inventory fluctuated daily as needed medications were acquired through the supply chain or donations were made from service organizations working in the area. Several days were spent trying to organize and account for the different types and quantities of medications in the stockpile. The use of an electronic database designed before the event could have significantly streamlined this process. In addition, the information gathered on the types of illnesses treated and pharmaceuticals used could be combined to design a recommended stockpile that could be deployed and a plan for re-supplying the stockpile over time. These data can provide information important to planning both before and during an emergency.

Another important task was tracking the number of hours worked by staff. These data are useful, if not absolutely necessary, for both reimbursement purposes and also for future planning. The average number of hours worked by staff members representing different professions and specialties can be used post-event to evaluate what type and level of staffing are appropriate for future deployments. In addition, this information is useful to ensure accountability for hours worked and appropriate reimbursement of volunteer staff. Also, if this information is collected, it is possible to evaluate the number of staff on each deployment and then compare the hours worked to determine if the composition and size of the teams were appropriate for the scope of the mission.

Data collection during mass care scenarios is similar to data needs during a mass prophylaxis clinic. Data collection and epidemiology are considered by the CDC as examples of the "weights" of dispensing. The "weights" include essentially all activities performed at a clinic that take time and resources--everything from screening and triage to epidemiology and legal requirements--some of which are absolute requirements for the operation and must be performed. However, other activities such as quality control, patient tracking, inventory management, data entry, and education are all important to providing optimal care to patients, but often require

significant resources to complete and may be considered a luxury under certain circumstances. The value of such an activity to the population must be weighed against its cost in terms of available staff, time, and resources. Most importantly, there is no single standard that will apply to *all* disasters; each scenario must be evaluated based upon the unique circumstances of the emergency and available resources.

Type and Frequency of Illness Observed in Evacuees and Residents of the Biloxi/Gulfport, Mississippi, Region Following Hurricane Katrina

The application of surveillance data from a disaster response is wider than monitoring a population for disease outbreaks alone. The information collected is useful to characterize the population not only in terms of infectious disease risk, but also for chronic illnesses, mental health issues, and injuries. Fortunately, at least a small sample of data was obtained from patients treated during each of the three deployments as well as from evacuees who came to Indiana. These data have been analyzed to determine if there were differences between the types and frequency of illness seen during the deployments or in those individuals who evacuated the Gulf Coast region. This information was useful during the deployment, and the conclusions can also be used to guide future response efforts.

This was a new process that became a more integral part of the operations as time passed. The first team focused upon setup and coordination, with less time available to devote to maintaining logs. The second deployment established guidelines for maintaining logs, but even then the formats varied widely, making analysis difficult. Finally, the third deployment generally utilized a standardized, printed log sheet that was completed by staff members. The data from this group were more uniform and easily interpreted. Additionally, as teams improved upon the process for gathering information and learned which categories to focus upon, the data became richer and showed greater reliability. Thus, the data presented in this article are estimates of the frequency of illnesses seen within the different populations, and the conclusions that can be drawn are limited. This information provides guidance toward planning for future disasters, although it teaches more about the potential utility of data and the need to standardize the collection process.

For the purpose of comparison, data from one clinic with a steady caseload throughout the deployments were used to compare data from the evacuees, second, and third deployments. The log recovered from the first deployment obtained patient information from unknown locations, thus the comparison was also made with logs from the outreach teams for the other deployments. The evacuee data were gathered at a variety of locations: shelters, primary care offices, hospitals, and local health departments. The frequency of illness was calculated as the proportion of the total complaints made by those treated by the medical team. It is important to remember the differences that could exist in these populations and the danger for bias during analysis.

The data were grouped into four general categories of illness: infectious disease, chronic illness, injury, and mental health conditions. These categories were further divided into more specific groups for each type of disease. Overall, the major category of illness shifted over time. For most groups, the majority of individuals presented with either infectious or chronic disease, often with comparable frequencies. Figures 1 and 2 illustrate the frequency of infectious and chronic illness observed during the six-week deployment. Figure 1 compares evacuee data with those observed at the chosen clinic, while Figure 2 shows rates seen by the outreach teams.

Figure 1. Categories of illness observed in evacuees compared to **clinic** data over three deployments.

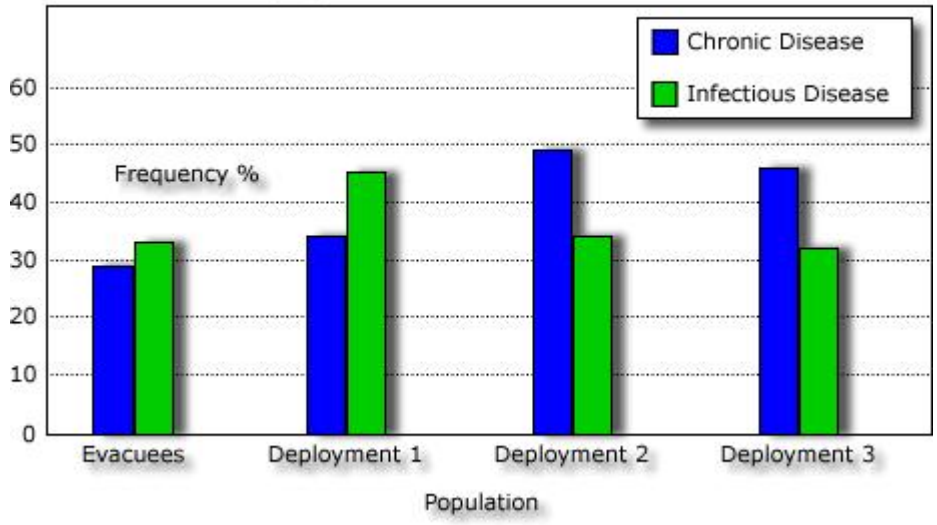
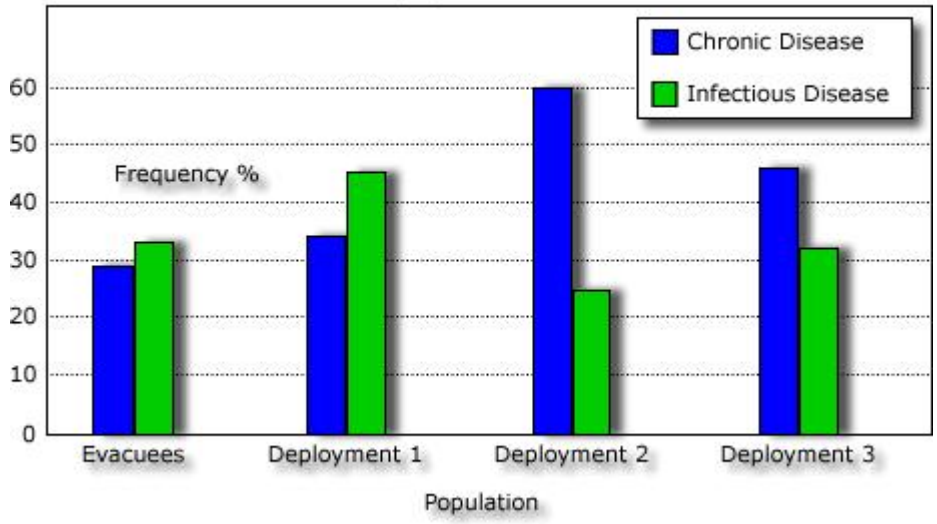


Figure 2. Categories of illness observed in evacuees compared to **outreach** data over three deployments.



Other types of health events include mental health issues and injuries. The frequency of mental health conditions generally varied from 13-26 percent in a clinical setting to as low 6 percent on the outreach teams. Accidental injury was generally seen in less than 10 percent of patients in the clinics but was especially low for the first deployment. The log reported only 2.6 percent of patients had wounds acquired through accidental injury that needed treatment but were not infected. Figure 3 illustrates the overall types of illness seen during the first deployment and shows that the majority of health events were rashes and wound infections. Figures 4 through 6 provide a comparison with the evacuees and other deployments.

Figure 3. Categories of illness observed during the first deployment.

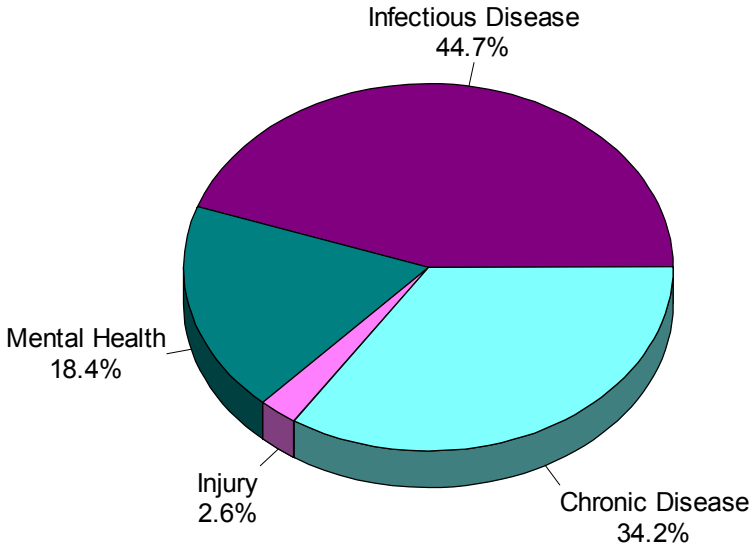


Figure 4. Categories of illness observed in the evacuee population.

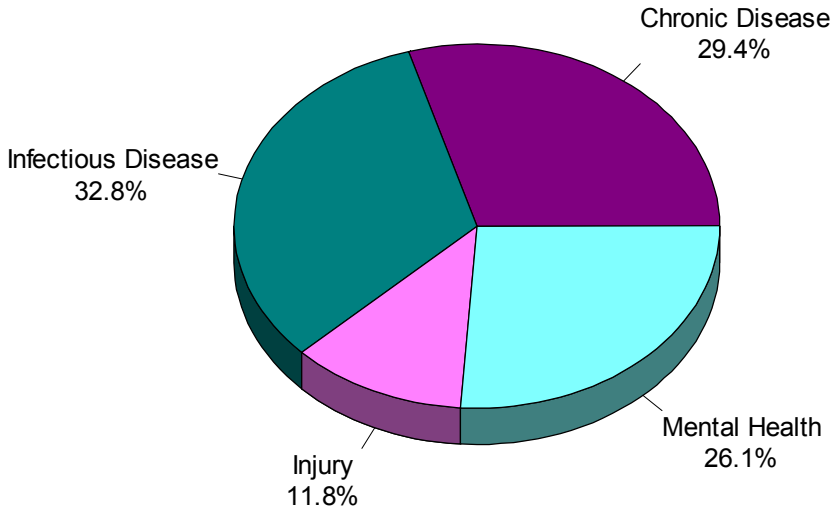


Figure 5: Categories of Illness observed during second deployment.

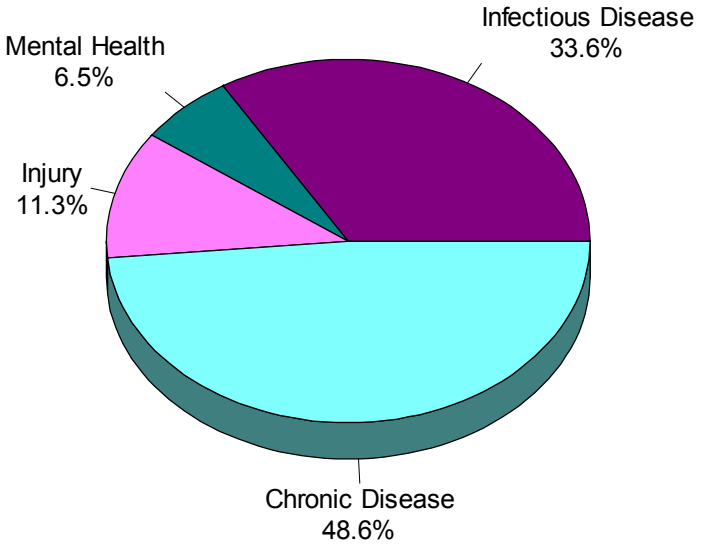
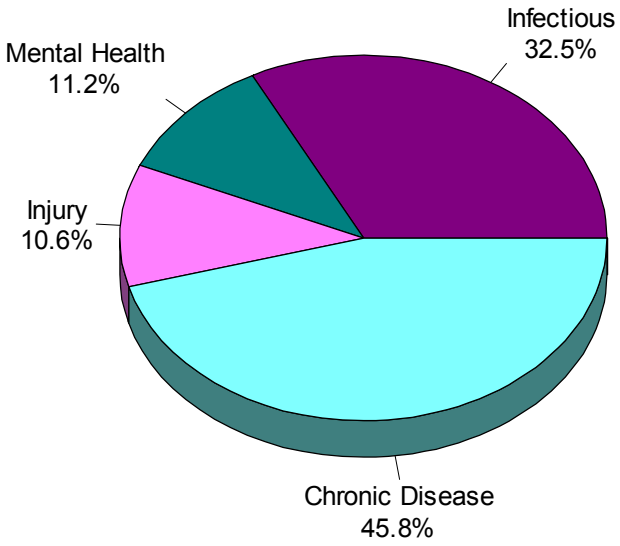
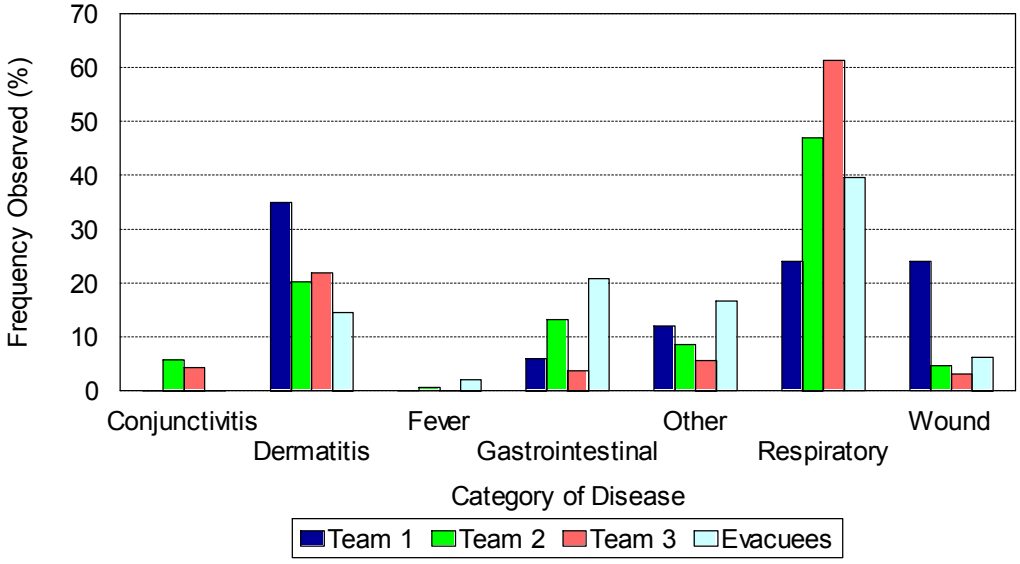


Figure 6. Categories of illness observed during third deployment.



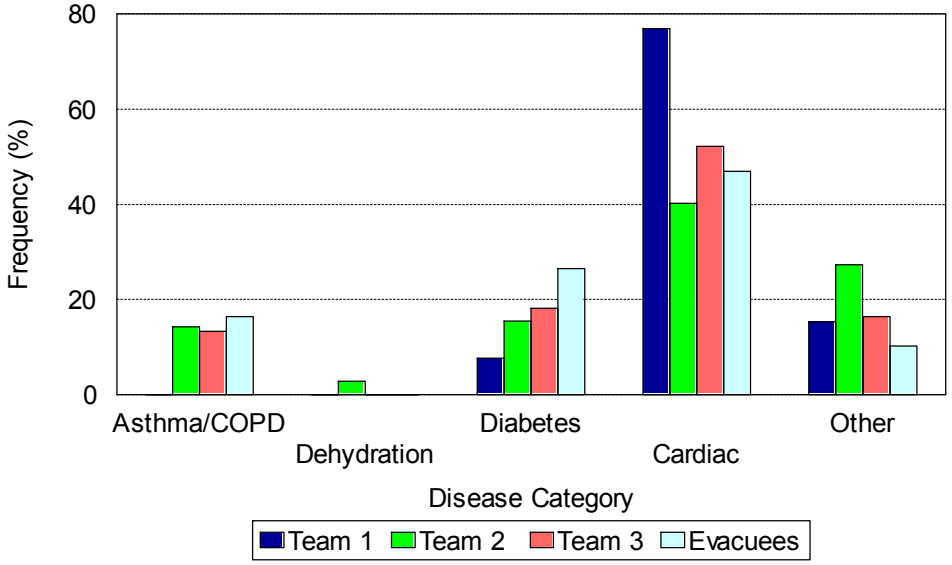
These figures illustrate the changes in the types of illness seen over time within the populations. The types of infectious and chronic illness observed also varied with time and population. Figure 8 shows the frequency of types of infectious disease for each of the four populations: deployments 1-3 and the evacuees. The figure shows that, generally, respiratory and dermatologic illnesses were the most common types of potentially infectious disease observed. However, it is likely that many of the rashes seen were allergic in nature and not infectious.

Figure 7. Categories of infectious illness and prevalence over time in individuals treated by the medical team.



Chronic disease was another category of illness observed in many patients. This was often the most prevalent disease category or it closely followed the frequency of infectious illness. Figure 9 demonstrates the types of chronic illness observed during the three deployments and in the evacuee populations. Hypertension or cardiac disorders accounted for the greatest proportion of chronic illness evaluated and treated. However, it is also apparent that the "other" category often represented a significant portion of the chronic disease in the population. This shows the importance of the type of data collected and ensuring that the metrics are appropriate.

Figure 8. Categories of chronic disease and prevalence over time in individuals treated by the medical team.



Data analysis can be utilized to determine what type of resources, such as medications or medical supplies, should be included in a cache, either stockpiled or at least made available to the deployed teams. The discussion of the "other" category demonstrates the limitations of the metrics used to analyze the data and importance of types of illness not traditionally included in surveillance. For the chronic disease category, the "other" types of illness included allergic rhinitis and gastroesophageal reflux disease (GERD), which are often treated with medication. Medications to treat these conditions were generally readily available to the medical teams through the resource chain; however, it is important to not overlook these common, readily treatable ailments that could potentially cause great discomfort in patients if left untreated.

Another issue that should be considered after natural disasters is the amount of tetanus vaccine that must be available. Generally, the majority of individuals encountered by the medical team received a tetanus shot. The first team estimated rates were as high as 75 percent, while data from the third team showed that the number could have dropped below 50 percent. However, considering that often several hundred individuals were seen daily, it is necessary to have not only supplies available, but also adequate storage space and conditions to ensure the appropriate temperature is maintained for the vaccine. In addition, it is important to standardize the information collected about individuals who receive a tetanus shot. Some teams used separate logs for tetanus only, which often did not include information that could be analyzed or the data were not collected at all. The vaccinations were a major part of the operations, and the importance of accurate documentation should not be overlooked.

A discussion of the best practices for data collection shows the need to recognize pervasive issues and develop a standardized process for documentation. The clinic used for analysis of the population treated by the medical team utilized a format for data collection that could be repeated in future emergency responses. A printed, standard form was used to collect information including demographics, chief complaint, diagnosis, and treatment. The issues to consider when designing a standardized form include size and durability of the form, ease of use (check boxes versus handwritten), and secure storage of personal information.

What can be learned from this aspect of the Hurricane Katrina disaster response? First, an operation responding to a disaster is likely to evolve over time as the needs of the community and resources available to the teams both change. Each medical team had a different mission and varied capabilities to collect and interpret data, which is acceptable and should be expected. Careful consideration must be given, however, to the needs of the community in order to align the focus of the operation with their greatest threats. Information and evidence should drive the planning for deployments and field operations in the event of a disaster. The experience of the medical teams deployed to Mississippi and practitioners who treated evacuees in Indiana provides invaluable information for both epidemiologists and public health preparedness coordinators. The challenge now, in the aftermath of this terrible disaster, is to fully utilize the information gained to better protect all communities from the effects of public health emergencies.

Training Room

INDIANA STATE DEPARTMENT OF HEALTH IMMUNIZATION PROGRAM PRESENTS:
Immunizations from A to Z

Immunization and Health Educators offer this FREE, one-day educational course that includes:

- Principles of Vaccination
- Childhood and Adolescent Vaccine-Preventable Diseases
- Adult Immunizations
  - Pandemic Influenza
- General Recommendations on Immunization
  - Timing and Spacing
  - Indiana Immunization Requirements
  - Administration Recommendations
  - Contraindications and Precautions to Vaccination
- Safe and Effective Vaccine Administration
- Vaccine Storage and Handling
- Vaccine Misconceptions
- Reliable Resources

This course is designed for all immunization providers and staff. Training manual, materials, and certificate of attendance are provided to all attendees. Please see the Training Calendar for presentations throughout Indiana. Registration is required. To attend, schedule/host a course in your area or for more information, please contact **Beverly Sheets at 317-502-5722 or** hepbbev@aol.com or http://www.in.gov/isdh/programs/immunization.htm

Public Health Nurse Training Day

The ISDH Epidemiology Resource Center (ERC) is sponsoring a public health nurse training day on Monday, December 12, from 9:00-4:00, Indianapolis time, in Rice Auditorium at the Indiana State Department of Health, 2 North Meridian Street, Indianapolis. This training, targeted

especially to nurses who have joined local health departments within the last five years, includes the latest information on several topics, including:

- reportable disease case investigation and case definitions
- laboratory results interpretation
- syndromic surveillance
- confidentiality
- disease-specific information

This is also a great opportunity to meet new ERC staff members. Approximately 30 seats are available. There is no registration fee, and all training materials will be provided. Participants will have one hour for lunch on their own and plenty of access to shopping in downtown Indianapolis. To register, please contact Trish Manuel at 317-234-2809 or tmanuel@isdh.in.gov by December 5, 2005.

ISDH Data Reports Available

The ISDH Epidemiology Resource Center has the following data reports and the Indiana Epidemiology Newsletter available on the ISDH Web Page:

http://www.in.gov/isdh/dataandstats/data_and_statistics.htm

HIV/STD Quarterly Reports (1998-June 05)	Indiana Mortality Report (1999, 2000, 2001, 2002, 2003)
Indiana Cancer Incidence Report (1990, 95, 96, 97, 98)	Indiana Infant Mortality Report (1999, 2002, 2003)
Indiana Cancer Mortality Report (1990-94, 1992-96)	Indiana Natality Report (1998, 99, 2000, 2001, 2002, 2003)
Combined Cancer Mortality and Incidence in Indiana Report (1999, 2000, 2001, 2002)	Indiana Induced Termination of Pregnancy Report (1998, 99, 2000, 2001, 2002, 2003)
Indiana Health Behavior Risk Factors (1999, 2000, 2001, 2002)	Indiana Marriage Report (1995, 97, 98, 99, 2000, 2001, 2002)
Indiana Health Behavior Risk Factors (BRFSS) Newsletter (9/2003, 10/2003, 6/2004, 9/2004, 4/2005, 7/2005)	Indiana Infectious Disease Report (1997, 98, 99, 2000, 2001)
Indiana Hospital Consumer Guide (1996)	Indiana Maternal & Child Health Outcomes & Performance Measures (1990-99, 1991-2000, 1992-2001, 1993-2002)
Public Hospital Discharge Data (1999, 2000, 2001, 2002, 2003)	

HIV Disease Summary

Information as of October 31, 2005 (based on 2000 population of 6,080,485)

HIV - without AIDS to date:

348	New HIV cases from November 2004 thru October 2005	12-month incidence	5.72 cases/100,000
3,586	Total HIV-positive, alive and without AIDS on October 31, 2005	Point prevalence	58.98 cases/100,000

AIDS cases to date:

399	New AIDS cases from November 2004 thru October 2005	12-month incidence	6.56 cases/100,000
3,769	Total AIDS cases, alive on October 31, 2005	Point prevalence	61.99 cases/100,000
7,355	Total AIDS cases, cumulative (alive and dead)		

REPORTED CASES of selected notifiable diseases

Disease	Cases Reported in September *MMWR* Weeks 36-39		Cumulative Cases Reported January -September *MMWR* Weeks 1-39	
	2004	2005	2004	2005
Campylobacteriosis	59	47	325	319
Chlamydia	1,491	1,771	13,803	15,183
E. coli O157:H7	8	5	41	43
Hepatitis A	13	5	49	42
Hepatitis B	4	11	35	41
Invasive Drug Resistant *S. pneumoniae* (DRSP)	8	13	124	160
Invasive pneumococcal (less than 5 years of age)	0	5	33	54
Gonorrhea	562	713	4,971	6,085
Legionellosis	7	1	38	14
Lyme Disease	5	3	22	24
Measles	0	33	0	33
Meningococcal, invasive	1	2	17	18
Pertussis	38	42	103	243
Rocky Mountain Spotted Fever	1	0	6	2
Salmonellosis	45	78	385	455
Shigellosis	36	13	169	116
Syphilis (Primary and Secondary)	3	3	45	47
Tuberculosis	6	13	91	106
Animal Rabies	3 (bats)	11 (bats)	10 (9 bats, 1skunk)	11 (bats)

For information on reporting of communicable diseases in Indiana, call the *ISDH Epidemiology Resource Center* at 317-233-7125.

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